Eastman, (Jos.)

With Compliments of the Author.

FOUR CASES

OF

Abdominal Surgery,

BY

Joseph Eastman, M. D.,

Indianapolis.

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FOUR CASES OF ABDOMINAL SURGERY, WITH REMARKS.*

BY JOSEPH EASTMAN, M. D.,

President, and Professor of Diseases of Women and of Clinical Surgery in the Central College of Physicians and Surgeons, Indianapolis, Ind.; Consulting Surgeon to St. Vincent Infirmary, and to the Indianapolis City Dispensary.

Dr. Eastman briefly reported two operations for ovarian cysts, showing specimens. The first contained a lock of hair and weighed twenty pounds; the second weighed fourteen pounds and illustrated the advantages of operating before the patient's health was broken down; the cyst was shown.

He then reported two cases of removal of the uterine appendages for dysmenorrhœa, showing specimens, one a pyosalpinx as large as an orange, and remarked as follows:

These cases are not reported to show that removal of the uterine appendages is a remedy for dysmenorrhœa, except in such cases as a most careful and thorough examination by all methods reveals decided organic changes in the ovaries or tubes, or both combined; and not even then until the bromides and ergot, with hot milk in large quantities by the stomach, hot water in great quantities by the vagina, and a thorough trial of the galvanic current passed through

* Read before the Mitchell District Medical Society, and referred to THE INDIANA MEDICAL JOURNAL.

the diseased organs, have failed to cure. There are many such cases of hysteric, cataleptic, epileptic, morphine-poisoned, nerve-wrecked, brain-shattered, reason-dethroned, asylum-homed women, whose lives are, in their own words, "scarcely worth the living." These women are essentially sterile; these organs are decaying foreign bodies, and their removal justified by sound surgical principles.

I have here reported four abdominal sections since the meeting of the State Society. The first in care of Dr. Heath, at Sharpesville, Ind.; second, care of Dr. Abbott, at 211 Elm street, Indianapolis; third and fourth, care of Dr. Smith, Brazil, Ind. *

These four cases, together with those reported at the State Society this year, make seven without a death. I attribute this result to being able to get patients to submit to operations before the forces of death, plus the interference, were stronger than those of life.

I now purpose to discuss the questions: *When*, *where*, and *by whom* shall the abdomen be opened?

In determining the *vital* question—*when* to operate—I shall quote from a few text-books which are likely to be consulted by

*While reading proof, I add another removal of appendages, for salpingitis. Patient under care of Drs. Boynton and Hawley, Hope, Ind., making a total of eight without a death. The last three cases were operated on in a private hospital owned by myself.

practitioners having cases of ovarian disease under their care.

Dr. Goodell says: "When should the operation be performed? *Not* when the cyst has first been discovered, but when it has grown so large as to distend the belly, and when the woman has become thin and her health has begun to fail. The reasons for waiting are that the woman will have lived longer should the operation turn out to be a fatal one; that, the abdominal wall having become thinner, the incision will be proportionally shorter and shallower; that the patient being now less full-blooded, both hemorrhage and inflammation will not be so likely to occur; and that the pressure and rubbing to which the peritoneum has been for some time subjected will make it less vulnerable, and therefore less likely to take on inflammatory action."*

I seriously doubt if Dr. Goodell is now following this *teaching* himself; and yet his most excellent little book was quoted to me last summer when I was urging an early operation.

Edis, quoting Wells, says: "So long as an ovarian tumor does not materially interfere with the appearance, prospects, or comfort of the patient; so long as no injurious pressure is exercised by it on the organs of the pelvis, abdomen, and chest; so long as

*Lessons in Gynecology, p. 300. 1878.

heart, and lungs, digestive organs, kidneys, bladder, and rectum perform their functions without much disturbance; so long as there is no great emaciation, no very wearying pain, no distressing difficulty in locomotion; nor, so long as such injurious influence can be counteracted by ordinary medical care, the patient should be left to that care, undisturbed by any surgical treatment."*

Edis' valuable work is destined to a prominent place in our literature and Spencer Wells high authority, but such language is to-day a blot on the surgical map of the civilized world.

Having assisted Dr. Parvin in sixteen operations before beginning to operate myself, and having seen this favorable time watched for, I must emphatically dissent from such opinions. Edis could have quoted a more successful operator without going out of England, Mr. Tait having by work and words shown that "nothing succeeds like success."

Thomas, even in the last edition of his work, does not speak out emphatically in favor of early operating, and yet Thomas' book is in the hands of our best practitioners. Are doctors to blame for tapping and talking and doing all in their power to defer operation in the light of such teaching? I answer, yes, as better opinions are within

* The Diseases of Women—Edis. Pp. 322-3.

their reach. Contrast this with Keith, who has had such wonderful success, who, referring to his success, says: "This increased safety will encourage medical men to recommend earlier operations, which certainly few of them now do," and then adds "that very large tumors and bad adhesions increase the mortality there can be no doubt. For the last seven years," he says, "no death has occurred from non-adherent tumors, and the deaths that did occur, with one exception, were when the local difficulty prolonged the operation two hours or more."

Or, again, contrast their teachings with that of Baker Brown, who urged early operating in order to avoid changes in the cyst and peritoneum.

Or with what Emmet says (p. 864): "Experience has already demonstrated that, with the antiseptic method, we are justified now in undertaking the removal of ovarian tumors at a much earlier stage of their growth. In the greater number of cases from a year to eighteen months can be gained; and many advantages may be claimed in favor of the operation as soon as the tumor rises out of the pelvis. When the tumor can be detected for the first time in the abdomen, as a rule its walls are thin; a single cyst is common, and it is then free from adhesion. Under such circumstances, only a small incision is necessary in the abdominal wall, and if the

peritoneum is not opened until the oozing has ceased, the sac can be withdrawn without any fluid entering the cavity. The assistant can place his hand on each side as the sac is drawn out, so as to bring the abdominal walls in contact, and thus prevent the entrance of blood while the sutures are being introduced. In such a case I have completed the operation without the introduction of a sponge into the peritoneal cavity."

With these advantages, in connection with the antiseptic method, the rule, as to the best period in the growth of the tumor for its removal, has been reversed, and, as Dr. Keith has stated, "ovariotomy is not the operation it was even two years ago."

I am asked, "Do not our medical journals give the advanced views of our successful operators?" I answer, "Yes." But still I can refer to five patients that, within a period of three years, have died while waiting for a proper time for the operation. One in the care of Dr. Herr, Westfield, Ind.; one in care of Dr. Roope, Columbus; one formerly under care of Dr. Banker, Columbus, Ind.; one under care of Dr. Bowers, Clinton County; and one under care of Drs. Linn and Edison, Bourbon, Ind. I fault none of these gentlemen. Yet, that there was a time in each of these cases, when an operation might have saved life, I sincerely believe and challenge

contradiction. Other have died after late operations, that earlier efforts would have saved, a few of them in my hands. To countenance any delay then is, surgically, a crime; theologically, a sin.

It has been suggested to me that, like cataract in the eye, these ovarian tumors must ripen before removal. They do ripen, not for the scalpel and ligature of the successful surgeon, but for the *harvest* and *sickle* of *Death.*

Mr. Lawson Tait, of Birmingham, Eng., has astonished the world by one hundred and twelve (112) operations for ovarian diseases without a death. He attributes his success to perfect cleanliness, good efficient nurses, increased personal experience, and unremitting attention to all the minute details of his work.

For the sake of American operators, who are earnestly pleading with women to accept operations earlier, and for the sake of saving precious human lives, he ought to have said, that his tumors come to him, in most cases, while they are small. He said at Philadelphia:

"*My own experience leads me to believe that if the practice were uniform all over the world of removing ovarian tumors as soon as discovered, the mortality would not be one per cent.*"*

* A lecture delivered, by invitation, at the Jefferson Med. Coll. Hosp., Sept. 15, 1884.

I have his words, over his *own* signature, to this effect, in a personal letter to me, dated January 5, 1885. After stating that he operates on every tumor that comes to him, large or small, he uses these words:

"The fact is, however, that as tumors come to me at a much earlier stage than they used to do, the result, which you very properly argue in favor of, is that in the majority of the cases the operation is performed in the very early stage.

"Yours very truly,

[Signed,] "LAWSON TAIT."

This is to my mind an acknowledgement that early operating is the keystone of the arch, upon which his *well-merited fame* shall ever rest. When he is suggesting the urgency of an operation he is not now met with the argument—that such-a-lady, who had such an operation, *died*. Deaths are *rare*. Why? Because delays are rare. Our experienced operators succeed with the same class of cases he succeeds with; but their mortality is continually increased by their efforts to save neglected cases. In some instances the delay has been advised by their attending physician; this is *wrong*—it is an injustice to American operators—it is a sin of commission: it is also a sin of omission, if we consent to delay by indifference or silence, or by that great obstacle to successful operation—that "surgical crime,"—tapping. Why denounce it so severely? Because

you can not know what you tap! You don't know the consistence of the fluid: it may run through an aspirator needle, or be so thick that it would not run through a five-inch stove-pipe; it may be a malignant mass, and still seem to be fluid; it may be a cyst with thick partition walls, and the needle enters an extremely vascular point, blood being poured out to undergo decomposition after the needle is withdrawn: or the cyst and abdominal walls no longer in close contact may allow the escape of fluid, septic or otherwise, into the peritoneal cavity.

I only intended to discuss when, where, and by whom should the operation be performed, but I could not think of discussing these questions without again condemning tapping as at best a delusive hope. Again, I have failed to find any publication of American origin emphatically condemning tapping ovarian cysts, bearing date earlier than my article of July 11, 1884, read before the Indiana Medical Society, and published in the "Transactions" and in the Cincinnati Lancet and Clinic, Aug. 23, 1884. I insisted then, I want now this tapping cysts stopped, as it delays operating; and I want as early operating in Indiana as in England. When we get it, experienced, expert operations will have as good results.

I have no apology to make for continually presenting my work to the profession. I

hope thereby to induce doctors to accept views in advance of some of the text-books I have quoted, and enable them to be instrumental in saving women's lives. I want every doctor and every woman to be wide awake to the advantages of early operating, and to the danger and death of delay.

As to *where* the operation should be done, I answer, the private hospital is the ideal place—where we can have nurses with experience in all that pertains to the preparations for operating and after-treatment of abdominal cases. Still the mental condition of the patient must be considered. The home-sick woman and soldier have little stamina for successful battle. The love of "home, sweet home" was strong in woman's heart long before Payne wrote the verses; it is sometimes her very life, and we are, therefore, justified in operating occasionally at the patient's home, if we can transfer to it our experienced nurses with all the discipline and cleanliness of a private hospital. We must occasionally yield to the patient's wish, if in no other way they can be induced to have an early operation.

As to *who* should operate. To attain success in surgery, as in music and art, there must be a natural adaptation. The planning of a great battle requires little more than the arranging and execution, in *all* its *endless* detail, of an ovariotomy. The best operators

frequently resolve to have something a little different next time. The surgeon must remember that this operation is the crowning glory of his art, and bring to bear the accumulated wisdom and experience of his life. The delicate adjustment in hare-lip, the cool, deliberate head needed in lithotomy, are no disadvantage in ovariotomy.

Ovariotomy is not now, and never will be, an operation to be undertaken by everybody. "One ought to see the abdomen opened many times before he attempts it himself." The thousand little points one picks up in assisting, or doing operations, or conducting the after-treatment, will always remain as lessons peculiar to each operator, which he can never impart to others, by words written or spoken, or appearances photographed. The view of the interior of an abdomen after death, in a fatal case, will suggest more for the success of the next case than a week's turning of leaves of books.

The attempt to place this operation among those to be undertaken by every one who does surgery or teaches obstetrics or gynæcology, is wrong. It has cost *lives*, and it can no more be done than can cataract be successfully removed from the eye by every surgeon. *That* operation has long been given over to those specially fitted by *nature*, by *knowledge of anatomy* and *pathology*, by *instruments*, and by *skill*: let abdominal

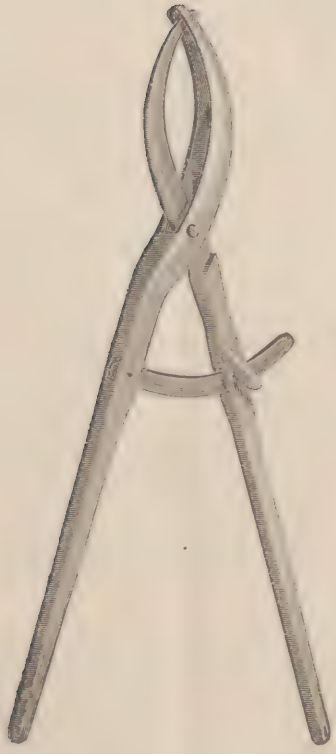
surgery be practiced by the few: and let all operators report their *work honestly*. Mr. Tait, in his last report, locates his patients, and thereby set a good example, which some of our St. Louis friends would do well to follow. In hearing the report of so many cases by operators who fail to give the data by which we could learn the whereabouts of their patients, I am reminded of Hume's Philosophy: He preferred to believe that twelve apostles had lied, rather than believe that one man had arisen from the dead; he reasoned that lying was twelve times more common than resurrection of dead men.

Philadelphia medical journals are prompt to publish the work of a few Philadelphia surgeons, especially if it is presented to their obstetrical society. It is right that they should; at the same time, I trust the day is not distant when they will stop looking into the large end of their opera glasses while they glance at Indiana journals and Western operators.

While assisting Dr. Parvin, I threatened to invent a clamp to suit me. I have used my invention some ten times, and am well suited, as have been all who have seen it work.

The clamp, as here shown, has the following advantages:—

1. It is long enough to enable the assistant holding it to be entirely out of the operator's way.



II. It is strong enough; that there need be no fear of its breaking, no matter what force is exerted, purposely or otherwise.

III. It has no complicated machinery, to get out of order at a critical moment. "The simplicity of an instrument is a measure of its success."

IV. No matter how large the substance grasped, nor how small, the pressure is the same at either extremity of the clamping jaws, the latter being so constructed that they will not cut nor allow any substance to slip.

V. It will crush a substance as small as a shoe-string, or the base of a tumor six inches in diameter. This is sometimes an advantage where the pedicle is short and more room needed for the ligature.

VI. It *instantly* arrests all communication between patient and tumor, so that air striking the peritoneal surface of the tumor can not chill the patient—and cold venous blood returning to the large veins is an important source of shock.

VII. It instantly arrests all escape of arterial blood, which is sometimes great when we have broken up the partition walls of a cyst to reduce its size.

Prof. A. C. Bernays, of Saint Louis, says: "I have used the clamp in a case of malignant ovarian tumor. It worked admirably. Dr. A. J. Bock held the clamp, and he as well as myself, were charmed with the work that was done. I am sure that it is a time and labor-saving instrument. Its usefulness will be praised by all who ever will use it."

In removing small ovaries and tubes, the opening (which is usually the size of the patient's mouth,) is made absolutely free from blood; but in introducing the fingers to find and bring the ovaries to the surface, there may be a separation of the peritoneum from the fascia, or integument from the muscle, allowing a considerable amount of blood to drip into the abdomen. To prevent this I have, for some time, caught the margin of the peritoneum in torsion forceps, holding

it well up, and cutting off the piece of flesh contused in the grasp of the forceps before closing the wound. In my last four operations, before introducing the fingers, I have stitched, with a small crooked needle, the peritoneum to the integument at each angle of the wound, leaving the ends of the thread long, to be held by an assistant if necessary.

These threads are not removed until the wound is closed; thus keeping the peritoneum where I want it from the first. My sponges do not go into the abdomen for blood, as I know, in the absence of adhesions, there is none. If adhesions are broken up, we know that the blood does not come from the margins of the abdominal wound—to me an important item. Conscientious attention to all the minute anatomical, pathological, mechanical, and surgical details is, to my mind, the measure of our success in abominal surgery.